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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JOHN XIAO-JIANG QIAN, M.D.** **P. O. Box 675594** **Rancho Santa Fe, California 92067** **Physician's and Surgeon's Certificate No. A72430,** Respondent.	Case No. 800-2014-009588 OAH No. 2018-030914 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about July 1, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A72430 to John Xiao-Jiang Qian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(d) Incompetence.

" ..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

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7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

9. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import."

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"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent has subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of Patients A, B, C, D, and E,[1] as more particularly alleged hereinafter:

11. **Patient A**

(a) On or about August 28, 2009, Respondent had his first visit with Patient A, a then-53-year-old female.[2] Patient A was referred to Respondent by her primary care doctor for a comprehensive pain management consultation. At this first visit, Respondent documented Patient A's chief complaint as chronic back pain; he performed a full evaluation including taking a complete medical history and performing a physical examination of the patient. Respondent concluded that Patient A was a good candidate for lumbar epidural steroid injections, had her sign a pain treatment agreement, and directed her to return for a follow-up visit in one month.

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[1] Letters A, B, C, D, and E are used for the purposes of maintaining patient confidentiality.

[2] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (November 17, 2017) involving Patient A is for informational purposes only and is not alleged as a basis for disciplinary action.

(b) Between 2010 and 2015, Respondent, as a pain management specialist, routinely prescribed controlled pain medications in high doses to Patient A including, Norco[3] and Duragesic[4] patches. The Morphine Equivalent Doses[5] (MED) provided to Patient A with Respondent's opioid prescriptions were consistently high, and Respondent did not document the justification as to why higher opioid doses were needed for this patient. In addition, Respondent routinely prescribed to Patient A high doses of Soma,[6] a controlled drug with known sedative and abuse potential. During this same timeframe, Patient A was also regularly receiving prescriptions for benzodiazepines[7] from her primary care doctor. Respondent,

[3] Norco, a brand name for acetaminophen and hydrocodone bitartrate, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The Drug Enforcement Administration (DEA) has identified opioids, such as Norco, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.)

[4] Duragesic patches contain fentanyl, an opioid pain medication and Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Duragesic patches are for use only on the skin, and are used to treat moderate to severe chronic pain around the clock and are removed and replaced approximately every seventy-two (72) hours. The DEA has identified fentanyl as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at pp. 34.)

[5] For a comparison of opioids doses, MED was developed to equate the many different opioids into one standard value. This standard value is based on morphine and its potency, referred to as morphine equivalent doses. The Centers for Disease Control and Prevention (CDC) states, "Higher dosages of opioids are associated with higher risk of overdose and death – even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk."

[6] Soma, a brand name for carisoprodol, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, published comment on carisoprodol, dated March 2014, "[c]arisoprodol abuse has escalated in the last decade in the United States…According to Diversion Drug Trends, published by the Drug Enforcement Administration (DEA) on the trends in diversion of controlled and non-controlled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

[7] Benzodiazepines (e.g., lorazepam, temazepam, diazepam, and alprazolam) are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and (continued…)

despite his knowledge of additional benzodiazepine prescriptions, did not document any discussion and/or obtain consent from Patient A about the risks involved with concurrent use of high dose opioids, benzodiazepines, and Soma.

(c) On or about August 25, 2011, Patient A received a prescription for Dilaudid,[8] but there is no documentation in the patient's chart notes for prescribing Dilaudid and/or why it was even indicated as an additional pain medication.

(d) A chart note dated October 30, 2012, documenting a telephone call that had been made to Respondent's office by Patient A's adult son, indicated that the son had expressed concern that his mother was "over using her medication." In fact, Patient A's chart notes contain multiple references to complaints made by her son to Respondent's office about his concerns involving her "abuse of opioids."

(e) Multiple urine drug screens (UDS) ordered by Respondent for Patient A came back "negative" for the opioids that he was routinely prescribing to her. Respondent did not order any additional confirmatory testing following each negative UDS to confirm and/or explain the negative results. Respondent, despite multiple negative UDS results and the documentation of repeated complaints made to Respondent's clinic by Patient A's son involving alleged abuse of controlled pain medication, did not document any discussion with Patient A regarding the negative UDS results and/or other information about potential aberrant drug behavior.

(...continued)
are a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, they are used for the management of anxiety disorders or for the short-term relief of anxiety. Concurrent use of benzodiazepines with opioids may result in profound sedation, respiratory depression, coma, and/or death. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) For example, Valium is a brand name for diazepam, and Xanax is a brand name for alprazolam.

[8] Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as Dilaudid, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.)

(f) A chart note dated September 4, 2013, documented under the plan section that it had been "highly" recommended to Patient A that she consult with an addictionologist regarding her continued use of opioids as a chronic pain patient. Notwithstanding potential "red flags" involving addiction, no UDS screen was performed at this visit to confirm Patient A had been taking her controlled pain medications as prescribed. Instead, Respondent refilled all of Patient A's controlled pain medications at this visit. In fact, at no time during Respondent's care and treatment of Patient A did he ever reduce or modify the high dosage of opioids that were being prescribed despite the existence of "red flags" indicating aberrant drug use by Patient A. And, in terms of the recommendation, there was nothing documented in Patient A's medical records that showed she ever met with an addictionologist pursuant to the recommendation for a consultation.

12. Respondent committed gross negligence in his care and treatment of Patient A including, but not limited to, the following:

(a) Respondent failed to adequately monitor Patient A's opioid use;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered high dose opioids to Patient A; and

(c) Respondent failed to recognize the risk to Patient A associated with concurrent use of high dose opioids, benzodiazepines, and Soma.

13. **Patient B**

(a) On or about August 24, 2005, Respondent had his first visit with Patient B, a then-49-year-old female.[9] Patient B was referred to Respondent by her primary care doctor due to failed back surgery syndrome and chronic low back pain. At this first visit, Respondent documented Patient B's current medications which included high doses of opioids that Patient B had been taking for several

[9] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (November 17, 2017) involving Patient B is for informational purposes only and is not alleged as a basis for disciplinary action.

years. After this initial consultation, Respondent began seeing Patient B on a routine basis for pain management.

(b) On or about April 15, 2008, an UDS ordered by Respondent tested positive for 6-AM, which is a heroin by-product. A follow-up laboratory test was ordered which confirmed the results of the initial testing that found the presence of a heroin by-product in Patient B's drug screen. There was no documentation of any discussion, at any point in time, with Patient B regarding the UDS results. However, Respondent maintained Patient B for several years on high doses of controlled pain medications and other narcotics.

(c) On or about November 23, 2011, an UDS for Patient B tested negative for oxycodone even though Respondent routinely prescribed the controlled pain medication to her. At Patient B's next documented visit, on or about December 15, 2011, the chart note does not document any discussion with Patient B regarding the negative UDS results, but instead indicated the absence of aberrant drug taking behaviors. Significantly, Patient B's controlled pain medications are re-filled at this visit without any apparent discussion being held as to why she was not taking the drugs as prescribed by Respondent.

(d) On or about October 26, 2012, an UDS for Patient B again revealed "red flags" regarding aberrant drug behavior including, but not limited to, the detection of fentanyl which had not been prescribed to her by Respondent. At Patient B's next documented visit, on or about November 19, 2012, the chart note does not document any discussion with Patient B regarding the recent irregular UDS results. However, Patient B's controlled pain medications are again re-filled at this visit without any apparent discussion being held as to why she was not taking the drugs as prescribed by Respondent, including any documentation about why she tested positive for fentanyl.

(e) On or about May 24, 2013, an UDS for Patient B tested negative for opiates even though Respondent routinely prescribed opioid pain medication to

her. At Patient B's next documented visit, on or about June 7, 2013, the chart note does not document any discussion with Patient B regarding the recent negative UDS results, but again indicated the absence of aberrant drug taking behaviors. Significantly, Patient B's controlled pain medications are re-filled at this visit without any apparent discussion being held as to why she was not taking the drugs as prescribed by Respondent.

(f) In 2014 and 2015, Respondent, with full knowledge of numerous "red flags" raised involving potential aberrant drug use during his care and treatment of Patient B, occurring over several years, continued prescribing her high doses of addictive pain medications and did not document a UDS for Patient B during this two-year span. Nor did Respondent document in the chart notes the reasons for changing Patient B's opioid medications.

(g) The first Controlled Substance Utilization Review and Evaluation System[10] (CURES) report found in Patient B's medical chart maintained by Respondent's clinic was not obtained until on or about January 7, 2015. Respondent was aware that Patient B's primary care physician had been prescribing other controlled medications including, but not limited to, Valium and Soma. Significantly, Respondent, with full knowledge of the various controlled medications being prescribed to Patient B by him and other physicians, did not document any discussion and/or obtain consent from Patient B about the risks involved with concurrent use of high dose opioids, benzodiazepines, and Soma.

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[10] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

Nor did Respondent, in light of the MED due to high doses of opioid medications that were routinely prescribed to Patient B, adequately document the justification as to why such high doses were needed for this patient.

(h) Respondent, following his review of the multiple UDS's taken by Patient B, did not correctly interpret the metabolic breakdown of benzodiazepines contained in the test results.

14. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent failed to recognize signs of probable substance abuse;

(b) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered high dose opioids to Patient B;

(c) Respondent failed to recognize the risk to Patient B associated with concurrent use of high dose opioids, benzodiazepines, and Soma;

(d) Respondent failed to adequately document reasons for changing Patient B's opioid medications; and

(e) Respondent failed to correctly interpret the metabolic breakdown of benzodiazepines contained in the UDS test results.

15. **Patient C**

(a) On or about September 10, 2008, Respondent had his first visit with Patient C, a then-35-year-old male.[11] Patient C was a worker's compensation patient referred to Respondent by a spine surgeon for discography. After the first visit, Respondent assumed care of Patient C's opioid therapy and maintained him on multiple controlled medications including, but not limited to, Norco and Soma.

(b) On or about June 29, 2009, Respondent reviewed a note from a psychologist regarding Patient C which diagnosed him with alcohol abuse disorder

[11] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (November 17, 2017) involving Patient C is for informational purposes only and is not alleged as a basis for disciplinary action.

in partial remission and major depressive disorder. At no time during Respondent's care and treatment of Patient C did he document a discussion with the patient regarding abuse of alcohol; nor did he incorporate this potential risk into the patient's treatment plan, at any point, even though he continued prescribing to Patient C high doses of potentially addictive opioids and sedatives.

(c) Respondent did not document a single UDS for Patient C in 2010, 2011, 2013, or 2014.

(d) From 2010 through 2015, Respondent maintained Patient C on a combination of drugs including, but not limited to, high doses of opioids, Valium, and Soma. Respondent did not document or obtain consent from Patient C about the risks involved with concurrent use of high dose opioids, benzodiazepines, and Soma. Nor did Respondent, in light of the MED due to high doses of opioid medications that were routinely prescribed to Patient C, adequately document the justification as to why such high doses were needed for this patient.

(e) On or about January 12, 2011, Respondent charted a pain management follow-up with Patient C. On that same date, Respondent issued a prescription to Patient C for multiple controlled medications, including Klonopin,[12] but there is no documentation in the patient's chart notes for prescribing Klonopin and/or why it was indicated.

16. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered high dose opioids to Patient C;

(b) Respondent failed to recognize the risk to Patient C associated with concurrent use of high dose opioids, benzodiazepines, and Soma; and

[12] Klonopin is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Klonopin is an anti-anxiety medication in the benzodiazepine family.

(c) Respondent failed to recognize Patient C's diagnosis of alcohol abuse in partial remission as a risk factor of addiction while continuing to prescribe high doses of controlled medications to this patient.

17. **Patient D**

(a) On or about December 4, 2006, Respondent had his first visit with Patient D, a then-31-year-old male.[13] After the first visit, Respondent assumed pain management care of Patient D for medical conditions relating to chronic pain, and maintained him on long-term opioid drug therapy for several years.

(b) Between in or around 2011, through in or around September 2015, Respondent prescribed Patient D a complex combination of multiple controlled pain medications including, but not limited to, OxyContin,[14] Dilaudid, Norco, Soma, and Xanax.

(c) Between in or around 2013, and in or around 2015, Patient D had a documented history of aberrant drug behavior including, but not limited to, illicit use of cocaine, early refills and/or lost prescription medications, and inconsistent UDS results.

(d) Between in or around 2013, and in or around 2015, Respondent continued to prescribe high dose opioids to Patient D despite ongoing pain ratings of eight (8) out of ten (10) or higher. In addition, Respondent frequently made changes to the types and/or dosages of opioids he routinely prescribed to Patient D.

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[13] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

[14] OxyContin, a brand name for Oxycodone HCL, is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

However, there was little or no documentation regarding any objective assessment of Patient D's pain and/or other measures that he had considered to reduce the patient's consistently reported high pain scores. In addition, there is little or no documentation of Respondent's rationale for frequent changes in types and/or dosages of opioids that he had routinely prescribed to Patient D.

(e) In or around November 2013, Patient D informed Respondent that his mother had thrown away his pain medications. Respondent simply refilled all of Patient D's pain medications.

(f) On or about April 16, 2014, Patient D was admitted to a hospital for one week for treatment of cellulitis. Patient D's creatinine level was measured at 4.7 upon admission. Significantly, hospital records documented that his UDS was positive for cocaine, and that he had bilateral draining abscesses on his upper arms. The hospital discharge summary indicated that Patient D had a long history of drug abuse and "shooting" cocaine.

(g) On or about April 30, 2014, shortly after Patient D's hospital discharge, Respondent saw Patient D for a clinical visit but there is no documentation in the chart note of the patient's recent hospitalization, UDS results, and/or abscesses on his arms.

(h) In or around November 2014, Patient D was admitted to a hospital for treatment of stage IV kidney failure with poly-substance abuse.

(i) By February 2015, Respondent was prescribing a complex combination of high dosages of opioids, benzodiazepines, and Soma for concurrent use by Patient D.

(j) In or around July 2015, Respondent gave an Opioid Risk Tool[15] (ORT) assessment to Patient D to complete for the first time at his clinic. However, the

[15] The ORT is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and (continued...)

form was left entirely blank except for the box for age which had been completed. The ORT, notwithstanding Patient D's long and documented history of aberrant drug behaviors, documented a score of only 1.

(k) Between in or around 2011, and in or around 2015, Respondent, notwithstanding the large amount of controlled pain medications that he had been prescribing to Patient D, never ordered a UDS for this patient.

(l) Between in or around 2011, and in or around 2015, Respondent, after years of maintaining Patient D on high dose opioids and benzodiazepines, never ordered a comprehensive metabolic panel for this patient.

(m) On or about September 12, 2015, Patient D was found dead in his bedroom. The cause of death was reported as accidental mixed medication intoxication.

18. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to, the following:

(a) Respondent failed to appropriately monitor Patient D's opioid use;

(b) Respondent failed to appropriately address Patient D's aberrant drug behavior including, his early refills and his statement that his mother threw away his controlled pain medications;

(c) Respondent failed to appropriately perform ongoing patient assessments of Patient D including, failure to note abscesses on his arms; failure to identify his renal failure through use of a comprehensive metabolic panel; and failure to address lack of improvement in his reported pain scores; and

(d) Respondent failed to recognize the risk to Patient D associated with concurrent use of high dose opioids, benzodiazepines, and Soma.

(...continued)
has been validated in both male and female patients. This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates *low* risk for future opioid abuse; a score of 4 to 7 indicates *moderate* risk for opioid abuse; and a score of 8 or *higher* indicates a high risk for opioid abuse.

19. **Patient E**

(a) On or about October 28, 2011, Respondent had his first visit with Patient E, a then-34-year-old female.[16] After the first visit, Patient E presented with a chief complaint of pain all over. Respondent documented pain-related diagnoses of rheumatoid arthritis, daily headaches, and chronic migraines. Respondent ordered a UDS which was positive for opioids and benzodiazepines.

(b) Between in or around December 2011, through in or around October 2012, Respondent routinely prescribed high dosages of opioids, benzodiazepines, and Soma for concurrent use by Patient E. Significantly, however, documentation was routinely missing from chart notes for many of these controlled prescriptions including, but not limited to, on or about the following dates: December 22, 2011; January 5, 2012; January 23, 2012; January 27, 2012–July 23, 2012;[17] July 30, 2012; August 2, 2012; August 5, 2012; August 25, 2012; September 6, 2012; September 21, 2012; and September 28, 2012.

(c) Between in or around December 2011, through in or around October 2012, Patient E was taking a significant amount of high dose opioids, but she never reported any improvement in her pain levels to Respondent. Respondent, notwithstanding Patient E's apparent failure to respond to continued opioid drug therapy, did not document his rationale for simply continuing her on the drugs. Furthermore, Respondent did not document that he had evaluated and/or discussed with Patient E any other therapeutic modalities to address the lack of improvement in her pain levels after ten (10) months of high dose opioid drug therapy.

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[16] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient E is for informational purposes only and is not alleged as a basis for disciplinary action.

[17] During this timeframe of approximately six (6) months, Patient E filled eighteen (18) prescriptions issued by Respondent's clinic for controlled pain medications without a single documented visit to Respondent's clinic.

(d) On or about October 5, 2012, Patient E died of a drug overdose. The cause of death was reported as accidental overdose of acute morphine, codeine, diazepam, doxepin, and hydroxyzine intoxication.

20. Respondent committed gross negligence in his care and treatment of Patient E including, but not limited to, the following:

(a) Respondent failed to maintain adequate records; and

(b) Respondent failed to assess the effectiveness of continued opioid drug therapy for Patient E in light of her reporting no improvement in pain over ten (10) months.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent has further subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

22. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to document the prescription for Dilaudid issued to Patient A on or about August 25, 2011; and

(c) Respondent failed to get a consultation with an addictionologist for Patient A.

23. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

24. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to incorporate the information in the treatment plan regarding the risk Patient C had for addiction due to his diagnosis of alcohol abuse disorder in partial remission; and

(c) Respondent failed to document the prescription for Klonopin issued to Patient C on or about January 12, 2011.

25. **Patient D**

(a) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to get a completed ORT from Patient D;

(c) After 2011, Respondent failed to get a UDS from Patient D; and

(d) Between in or around 2013, and in or around 2015, Respondent failed to appropriately document his rationale for the changes in opioids that he had prescribed to Patient D.

26. **Patient E**

(a) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

27. Respondent has further subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in his care and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

28. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

29. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

30. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

31. Respondent has further subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to Patients A, B, C, and D, as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

32. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

33. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

34. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

35. **Patient D**

(a) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

36. Respondent has further subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of Patients A, B, C, D, and E, as more particularly alleged hereinafter:

37. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

38. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

39. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

40. **Patient D**

(a) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein.

41. **Patient E**

(a) Paragraphs 19 and 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

42. Respondent has further subjected his Physician's and Surgeon's Certificate No. A72430 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 11 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A72430, issued to Respondent John Xiao-Jiang Qian, M.D.;

2. Revoking, suspending or denying approval of Respondent John Xiao-Jiang Qian, M.D.'s, authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent John Xiao-Jiang Qian, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 29, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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Doc.No.81870518